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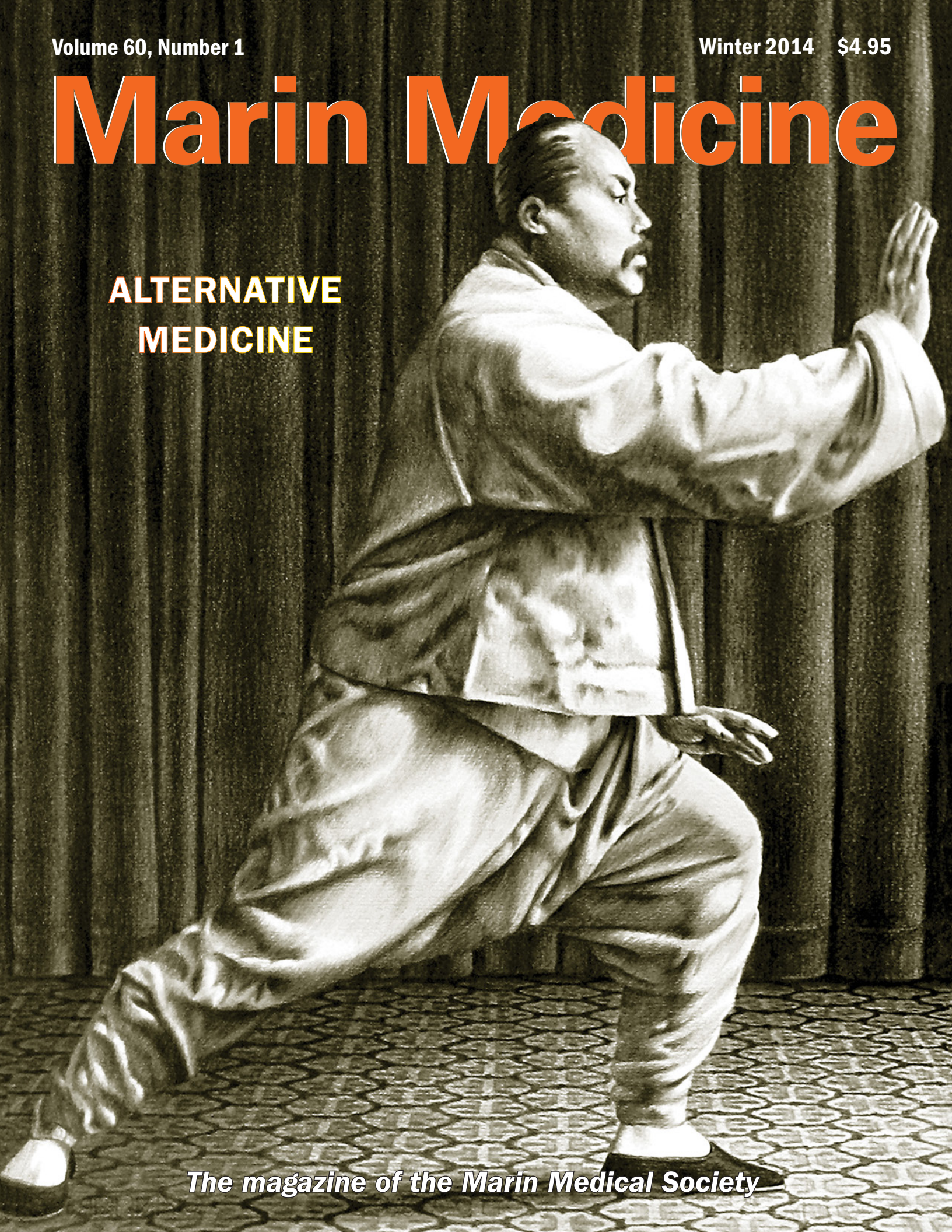
Marin Medicine

ALTERNATIVE MEDICINE



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An Antidote to Anecdote

Sal Iaquinta, MD

Any discussion of alternative medicine requires an understanding of the difference between an anecdote and a scientifically proven fact.

But to begin, we need a definition of alternative medicine. Loosely, the term refers to any alternative to accepted medical treatments or methods. Labeling treatments as "alternative" is tough, however, because modern medicine is always moving, and accepted treatments are always changing as new discoveries are made and tested. Was hand-washing an "alternative medicine" prior to acceptance of germ theory? Plenty of surgeons thought Dr. Semmelweis was crazy when he first put forth the idea that hospital staff were transmitting the microbes responsible for puerperal fever between patients.

It's important to understand that treatments considered "alternative" might not be wrong—they just might be poorly studied. That's how treatments cross from alternative medicine to evidence-based medicine: by rigorous studies involving large numbers of people, with minimal variables between the study group and the control group.

Alternative medicine often includes treatments supported solely by anecdotal evidence, which means evidence based on stories, observations or word-of-mouth. The patient who told me that she "read a blog about a woman with melanoma and after her surgery she started using an herbal supplement from South America and she is still alive five years later" was telling me an anecdote. For a thousand dollars a month, she could get the same herbal concoction shipped to her.

Dr. Iaquinta, an otolaryngologist at Kaiser Permanente San Rafael, is the author of The Year THEY Tried To Kill Me, *a memoir of his surgical internship.*

Likewise, the patient who told me that he didn't want to quit smoking because "My dad smoked two packs a day his entire life, and he lived to 86 and never got cancer" was also telling me an anecdote.

Distinguishing between an anecdote and scientific proof comes down to elucidating causality. Simply, if A then B. You check into a hotel room and see a row of light switches. In a few seconds, you understand that the first switch turns on the light near the door, the second switch turns on a light near the bed, and the third turns on the ceiling fan. Easy, right?

But sometimes it's "if A + B, then C." Or it's "if no A and no B, then 10% chance of C; but if A + B, then 85% chance of C." The more complex the relationship, the lousier we are at understanding and determining causality. Scientists determine causality by studying the same event in large numbers and looking at the outcomes. Studying one smoker does nothing to say how bad smoking is because lung cancer is not simply "if A, then B." But by studying hundreds of thousands of people, we know that my patient's anecdote is not a reliable prediction of how everyone who smokes will fare.

No current health issue better highlights the difficulty of determining causality than autism. Ever since the former surgeon Andrew Wakefield (he has since lost his license) published findings in 1998 of 12 children with intestinal inflammation and "behavioral symptoms," scientists have been trying to set the record straight. Wakefield claimed that the onset of autism occurred shortly after MMR vaccination in 8 of the 12 children. His study in no way determined causality, nor was it large enough to determine a relationship between MMR and autism. Even Wakefield wrote, "We did not prove an association between measles, mumps, and rubella vaccine and the syndrome described." Too bad the media jumped on the suggestions he put forth.

Anecdotes are highly susceptible to false association, also known as "true, true and unrelated." In a false association, two events might happen simultaneously, but that doesn't mean they are related. The talk-show host Jenny McCarthy attempted to relate vaccines with autism when she said, "In 1983 the shot schedule was 10. That's when autism was one in 10,000. Now there's 36 [shots], and autism is one in 150." But she could have said, "In 1980, there were 6,000 McDonald's restaurants, but now there are over 34,000 . . . " Yes, many health-related factors have increased in the past 30 years, but it takes research on tens of thousands of patients to figure out what is really related.

Autism is not "if A, then B." A Danish study of 537,300 children, for example, found no difference in autism rates between MMR vaccinated and

unvaccinated children.[1] Instead, autism is likely "A + B + C + D = increased chance of autism," with none of the variables being immunization.

Anecdotes are seductively simple; medical science rarely is. A recent study of 625,000 children found that boys born to mothers who had induced labor had a 35% increased chance of developing autism.[2] But even this finding is complex and incomplete. Does the increased chance of autism come from the labor itself, from the drugs given, or from something related to autism? Although the researchers found a relationship, they have yet to determine a specific cause.

These studies are all very complex, and they're written in language that is neither exciting nor easily decipherable. Humanity has always tried to find the simplest explanation for any event. Having the Earth be the center of the solar system was very easy: you can see the sun arc across the sky every day. Copernicus needed a lot of observation and math to determine otherwise. And once he proved that the Earth wasn't the center of the solar system, plenty of people argued his findings.

All of which leads us to why people support anecdotal medicine. Their reasons aren't solely because they don't understand causality, or aren't good at math, or didn't do a study using a half-million patients. It is more about what they want to buy.

Everyone who offers treatment for any disease is actually selling you healthcare, whether you are paying for it or not. They are selling you an idea, an exercise, an herb, a carefully inserted needle, a quiet place, a vitamin, a surgery, a prescription drug, an injection, or even radiation therapy. If you can't distinguish the difference between treatments based on scientific merit, you just might go with the nicest salesman. I am sad to admit that there are studies suggesting one reason people seek alternative treatments is not because they don't believe in evidence-based medicine, but because they have had a bad experience with their doctor.

Doctor-haters aside, the reasons for pursuing alternative medicine boil down to Obama's first campaign: Hope and Change. We are willing to spend big money on Hope and Change.

We all want Hope. But when the doctor says there is nothing more that can be done for your cancer, recurring sinus congestion, backaches, migraines or stress, you still hope for a treatment. After all, you are still suffering. So you look online, and the search engine pulls up scientific studies right next to alternative options, in no particular order and often indistinguishable by look. For $29.95, you can order your bottle of hope. For the most part, it's safe or else they wouldn't be selling it, right? Wrong. Recent studies of Vitamin E supplementation, for example, showed that supplementation was associated with a higher incidence of prostate cancer. Likewise, some herbal combinations contain heavy metals that decrease the efficacy of blood pressure medicines.

Nonetheless, we hope something "natural" works without the side effects of the doctor's medicines. We desire something less expensive than a prescription drug. We seek out something simpler than the plan outlined by our physician. It's easier to eat more berries to theoretically prevent cancer than it is to lose weight, eat more veggies, avoid sugary drinks and exercise regularly (and yes, a healthy lifestyle has been proven to decrease cancer risk).

We also want to Change our situation, and we want to be an active part of the change. People want control of their lives and their future. Ailments take away control: your body is doing something you didn't plan. By taking alternative meds or going to alternative healers, you are taking an active part in getting better.

Modern medicine tends to be prescriptive. The patient doesn't get much choice, particularly in well-studied diseases with defined treatment algorithms. In contrast, alternative medicine offers meditation, tai chi, yoga and guided imagery—which are all about taking control of your mind and body. Alone, these techniques may not cure many problems, but they are part of the treatment, and they feel a lot better than chemotherapy.

So where does that leave us? On the one hand, anything that provides false hope while wasting time and money is a sin. On the other hand, any non-pharmaceutical treatment that can reduce stress and pain while potentially increasing strength and coordination is an integral part of not only recovery, but healthy living. Let's continue to separate the facts from fiction. ◇

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References

1. Madsen KM, et al, "Population-based study of measles, mumps, and rubella vaccination and autism," *NEJM*, 347:1477-82 (2002).
2. Gregory SG, et al, "Association of autism with induced or augmented childbirth in North Carolina birth record and education research databases," *JAMA Pediatrics*, 167:959-966 (2013).

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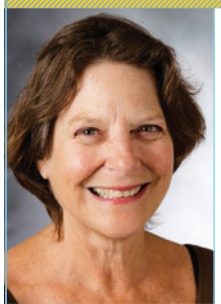

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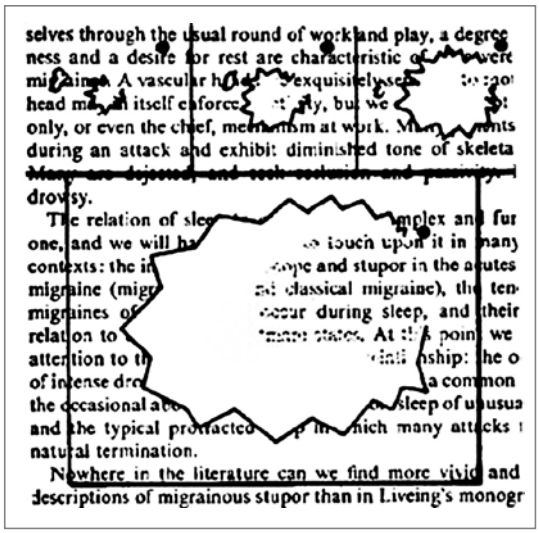
Intimations of Mortality

Dustin Ballard, MD

How can someone know if they are really sick? In the emergency department, life-threatening illness is often spotted as easily as pornography and poor fashion sense—we know it when we see it. But for most people, in most situations, sorting out true illness can be difficult. Many healthy folks cycle through EDs for nothingitis because they are anxious about disease, while some exceedingly unwell people stick it out at home, in full-on denial or stoically convinced that they can will themselves better. Others get so worked up with worry that they cause their coronaries to spasm them into right into a cardiac cath lab, while others just can't understand why their chest aches so deeply when they walk up stairs.

What's the difference between a mind that causes illness and one that can detect sickness early? This would seem to be an important question not only for emergency medicine, but also for every single living and thinking patient in the world. As physicians, we've all seen scores of panicky patients who have initiated their own domino effect of self-inflicted pathology. Take, for instance, the worried hypertensive, who takes his blood pressure reading at home again and again until it reaches an ischemic stroke climax.

Dr. Ballard is an emergency physician at Kaiser San Rafael.



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Nowhere in the literature can we find more vivid and
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Depiction of a migraine aura by Sir William Gowers.

Admittedly, patients seem much better at causing their own illness than they are at sensing illness before it occurs. But, there are some people out there who can reliably predict when they are getting ill. I find this intriguing. Do we, as humans, have a muted and under-recognized sense of our own sickness? With better recognition skills, could our patients serve as their own triage nurses? Phone advice lines are great, but wouldn't it be nice if our patients had a reliable sense of sickness—an epiphany of medical impairment?

Skeptical? Well, consider some examples. Let's start with the aura:

> [The aura that] precedes the headache of migraine is very mysterious. . . . There is a process of intense activity which seems to spread, like the ripples in a pond into which a stone is thrown. . . . The most frequent among the many forms is that of a small star near the fixing point; it enlarges towards one side, its rays expanding into zigzags.

So wrote British neurologist Sir William Gowers in 1906 in the *British Medical Journal*. Gowers was fascinated with the aura, so much so that he just couldn't help himself from describing it in exquisite detail.

> The most frequent prodroma is visual, as you all know. It is so characteristic as not to lead to confusion with epilepsy. But its features should be noted. The most frequent among the many forms is that of a small star near the fixing point; it enlarges towards one side, its rays expanding into zigzags, often coloured—the "fortification spectrum." Within it vision is dimmed by bright scintillation. It becomes faint when it has almost reached the periphery, and ends in various ways which are not relevant to our present object.

Auras, as we know, are also common in people with epilepsy. They come in a wide variety of forms—a kaleidoscope of lights, the smell of burnt toast, the sound of a public-address announcer booming—and may occur seconds to hours before the onset of a headache or seizure. For an epileptic or a migraineur, the aura is an extremely reliable indicator of impending symptoms, far more accurate than clinical evaluation or testing. Absent continuous fMRI or EEG monitoring, auras could be considered a gold standard of disease prediction; but we don't really understand where auras come from. We assume that they are associated with excitation of specific cortical areas preceding the onset of more generalized processes, but we have not yet been able to capture the neural circuitry of this process.

Is it possible that auras are a prominent manifestation of an innate mental ability to detect illness—a sense and premonition of sickness?

Consider some other health-related premonitions. Most or all of us have had some experience with a patient who accurately predicted his or her own demise. When I asked the partners in my home department about such premonitions of death (POD), all but one had a story to share—and the one who demurred gave this response, "Ugh no, but I can tell you about the thousands of anxious patients I've had to talk down from the ledge. . . . I hope you aren't going to turn this into an article."

Well, with apologies to Dr. Nau, I am. I can recall a patient of mine, a reasonably healthy middle-aged man with a small spontaneous intracerebral hemorrhage—caused, I initially reasoned, by poorly controlled hypertension. This man was neurologically intact, not on anticoagulants, and had no evidence of mass or aneurysm on imaging. It seemed like he would do just fine. Nonetheless, we prepared a transfer to a neurosurgical center for observation. My patient, stable and asymptomatic prior to transfer, asked me in a quite of matter-of-fact manner, "I'm gonna die, aren't I?" I assured him that this was not likely and that we were just taking a precaution, but he was convinced. "I'm gonna die," he said once more, softly, right before being loaded on the transport stretcher. And in fact he did die, just a few hours later, from multiple new bleeds caused by a rapidly progressive cerebral vasculitis.

A colleague tells a story of an aunt who suffered for months from headaches and dizziness of unknown etiology. After many visits to her doctor and many failed treatments, she became convinced that she was going to die. So convinced, in fact, that she began preparing and freezing dozens of meals, so her husband would eat well after she passed. Ultimately, her cerebral aneurysm was diagnosed just shortly prior to rupture. She did not die, but she was correct about being on the verge of death.

While POD is not a rich topic in the literature, there is some evidence supporting it as a real entity. For example, pregnant women who miscarry or otherwise lose their pregnancy sometimes experience a premonition beforehand. In a survey of women who suffered a stillbirth in the second trimester or later, 64% reported some premonition that their child was unwell.[1]

There are a also handful of case reports on POD sprinkled through the literature. Joseph Ngeh, in a 2003 letter to the Journal of the *American Geriatrics Society,* describes one such premonition in the in-hospital death of an elderly patient.[2]

> The patient's family had arrived by then. Although distraught, they showed no surprise at hearing about the patient's sudden death. During our conversation, I sensed that they had expected this to happen. Remarkably, the daughter-in-law volunteered that, when they visited the patient at 9 p.m. earlier that night, a mere six hours before the patient's first cardiopulmonary arrest, the patient had held her hand and mentioned that he would "die tonight."

Premonitions of death are also common in trauma patients. In a recent survey of more than 300 members of the Eastern Association for the Surgery of Trauma, 95% of the respondents reported encountering patients who expressed POD, and 50% agreed that patients expressing such premonitions had a higher mortality rate.[3] Fifty-seven percent also agreed with the belief that patient willpower affects outcome, while 44% were on board with the notion that patients have an innate ability to sense their ultimate outcome after injury.

Now, such "evidence" must be considered in the light of its limitations. Recall bias is an obvious limitation: there are surely many pregnant women and trauma patients who thrive or recover despite premonitions to the contrary. We must also distinguish POD from the ancient Chinese phenomenon of *hui guang fan zhao,* also called "Lazarus premonition." Screenwriters have made liberal use of this phenomenon for decades: the transient revival of the dying person before death. This situation is clearly different from POD because it is not so much a premonition as the recognition of a process that is nearly complete, like a song in its last chorus.

Absent a biologic explanation, it's impossible to prove that humans have an innate sense of sickness. I would argue, however, that we should not be overly skeptical. We accept the fact that animals may intuit when they or others are ill. Oscar the therapy cat, for example, has to date correctly foretold the deaths of more than 50 patients in a nursing home, curling up beside them within hours of their death.[4]

We also accept that certain animals—and my family's recently departed black Labrador was one of these—will innately put themselves out to pasture near the time of their death. (In the case of our Lab, this did not work, as my wife kept carrying her back inside from the bushes.)

It seems biologically and intuitively plausible that we humans have an innate sense of sickness. I think we can all agree that such a skill—maybe we could call it an *aurascope*—would be quite useful. Wouldn't it be nice to have as much faith in the word of a patient who intuitively predicts the onset of a heart attack or stroke as we would with an epileptic aura? Sure would save us emergency physicians a lot of stress—not to mention unnecessary testing. ◇

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References

1. Erlandsson K, et al, "Women's premonitions prior to the death of their baby in utero," *Acta Obstet Gynecol Scand* (June 13, 2011).
2. Ngeh J, "The phenomenon of premonition of death in older patients," *J Am Ger Soc* (Oct. 24, 2003).
3. Miglietta MA, "Premonition of death in trauma," *Am Surgeon*, 75:1220-26 (2009).
4. "Oscar (therapy cat)," www.wikipedia.org (2013).

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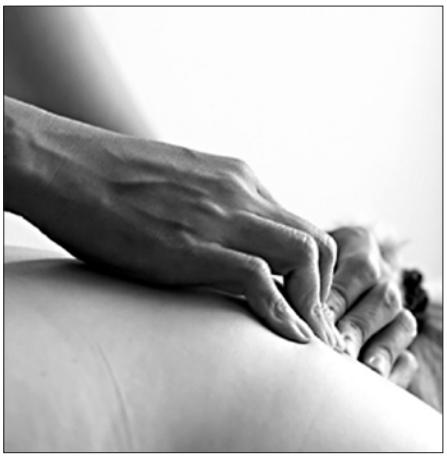
Nudging the Anatomy in the Right Direction

Jeffrey Etemad, DO



In discerning what osteopathy is and what it can do, it helps to have an osteopathic medical student perspective. Osteopathic students are taught the four tenets of osteopathy and apply them in all aspects of their practice:

- A person is a unity of body, mind and spirit.
- Structure and function are interrelated.
- The body has an innate capacity to heal itself.
- Rational therapy by an osteopathic physician is based on an appreciation of the above three principles.

Osteopathic education has gone through much evolution since the first osteopathic medical school opened in Kirksville, Missouri, in 1892. Schools of osteopathic medicine are today leaders in the teaching of manual medicine while also engaging in mainstream medical education of every description. Today there are 30 osteopathic medical schools in the United States, with the number growing steadily.

An osteopathic physician has full medical training in all the standard medical disciplines as well as hundreds of hours of additional training in osteopathic manipulation. Two equivalent terms have come into common use in scientific and teaching settings: osteopathic manipulative treatment (OMT) and osteopathic manipulative medicine (OMM). For a large population of patients, it makes a big difference to be manually treated by someone who really understands their diagnosis. Such patients will usually decide to receive manual therapy from osteopathic physicians, that is, physicians who have full medical practice licenses and the anatomical discrimination that is unique to osteopaths.

Dr. Etemad, a San Rafael physiatrist, is board certified in osteopathic manipulative medicine.

After graduating from Western University's College of Osteopathic Medicine of the Pacific, I completed a four-year residency in physical medicine & rehabilitation at the University of Michigan. My first four years in practice, including 10,000 OMT treatments, took place at St. Mary's Spine Center in San Francisco. Over the past 14 years of private practice in San Francisco and Marin County, I have performed approximately 25,000 OMT treatments.

Usually results using OMT are incremental, but once in a while something dramatic takes place. While at St. Mary's, I received a patient with low back pain who had a diagnosis of severe lumbar spinal stenosis. I considered not treating her with OMT because it seemed unlikely I could benefit her with hands-on treatment. But I decided to try applying a precise force with my hands to decompress her right sacroiliac joint, which felt compressed in my exam. When the patient returned for the next visit, she was smiling and seemed to be in a lot less pain. Over the next two years, that patient referred to me 50 patients who were her friends and/or family.

When performing OMT on the neuromusculoskeletal system, there is potential for interconnectedness with every organ system of the body. With OMT, we adjust the anatomy to its normal position, with normal motion, thus promoting normal physiology, which allows innate self-regulating powers of the body to accomplish what is necessary for healing to occur.[1]

In theory, osteopathy is effective for pain relief for several reasons. With

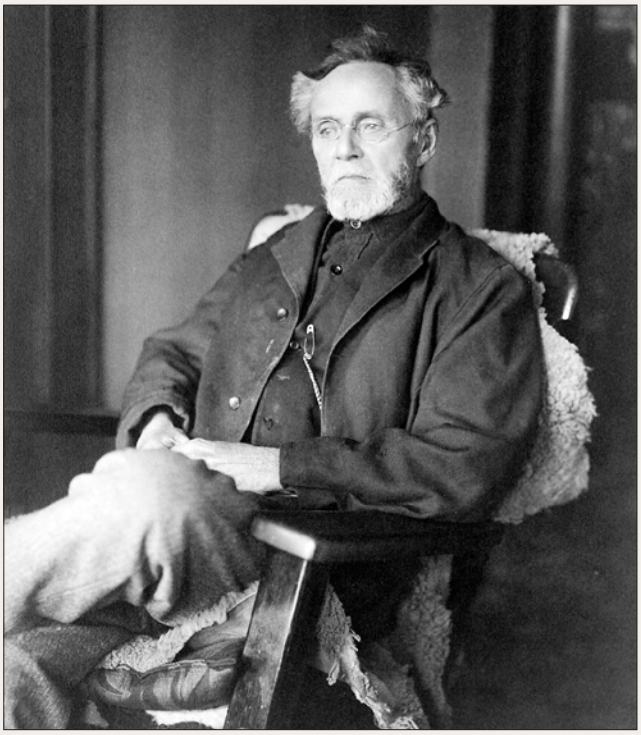
careful and accurate anatomical positioning of the patient's body, changes in muscle and connective tissue length and tone can occur. Changes may also take place in central, peripheral and autonomic nervous system tone, joint surface motion, and vascular and lymphatic function.[1]

The patients who seem to respond best to OMT are those who have experienced trauma and surgery. It makes sense that trauma, planned or unplanned, can produce a strain pattern that could remain in the tissue. With precise positioning of our hands, OMT can help release and unwind traumatic strains, either produced from a single event or from repetitive strains that accumulate over time. In my experience, radiculopathy and other acute conditions may require, in addition to OMT, adjunctive therapy, such as pain medications, epidural steroid injections and, rarely, surgery.

Some osteopaths use OMT as a supplement to standard treatment methods for addressing specific ailments, such as back and neck pain. Other osteopaths use OMT for all their patients, occasionally supplementing with more traditional methods and/or referring to colleagues as needed. Though I classify myself in the latter group, I believe it is good for the osteopathic profession to have a wide variety of types and scopes of practice.

I believe MDs should consider referring patients to osteopaths for almost any painful condition, and also for some conditions where pain is not the chief complaint, such as congestive heart failure, chronic obstructive pulmonary disease, asthma, otitis media and Parkinson's disease. My practice, for example, has become more general over the last few years, but the most common referral continues to be for back and neck pain.

OMT's efficacy in pulmonary infections was recently highlighted in the Multicenter Osteopathic Pneumonia Study in the Elderly (MOPSE). In this prospective, randomized controlled trial, OMT was evaluated as an adjunct



Dr. Andrew Taylor Still, Founder of Osteopathy

The founder of osteopathy, Dr. Andrew Taylor Still, was born in Virginia in 1828. While in his youth, he moved with his family to the Kansas-Missouri Territory, where he trained as a physician. He served with distinction as a surgeon for the Union Army in the Civil War and then returned to his medical practice. Over the next several years, he became progressively more disenchanted with medicine as it was practiced in that day. "Treatments" such as purgatives and leeches were common, as there was no knowledge of antibiotic therapy or the immune system. In his theories, he anticipated by 20 years key aspects of the immune system.

After 1874, Dr. Still began developing an alternative medical profession. The cornerstone of this new profession was anatomy. Dr. Still's tireless study included whittling a wood replica of each of the 206 bones of the human body. He found that when he adjusted the anatomy to normal, the body would take care of the rest.

To test his theories, Dr. Still travelled from town to town for many years treating patients. There reached a point when so many people wanted to receive his treatments that he decided to teach his method to others. His American School of Osteopathy (now A.T. Still University) opened in Kirksville, Missouri, in 1892.

During Dr. Still's lifetime, many promising advances occurred in osteopathy, including the opening in 1915 of the Still-Hildreth Sanatorium in Macon, Missouri, where thousands of mentally ill patients were treated with osteopathy. Many previously institutionalized patients improved dramatically or were cured.

In 1919, two years after Dr. Still died, osteopathic medicine had a stern test during the Spanish influenza pandemic. While allopathic hospitals used antitussives, opiates and strychnine, osteopathic treatment targeted autonomic changes, blood delivery, lymphatic drainage and biomechanical improvements in respiration. Recovery rates were much better in osteopathic hospitals.

For a comprehensive biography of Dr. Still, see *A.T. Still: From the Dry Bone to the Living Man*, by John Robert Lewis (Dry Bone Press, 2012).

to current pharmacologic therapy in elderly patients hospitalized with pneumonia. MOPSE demonstrated that OMT is helpful in treating lower respiratory infections, reducing length of stay in the hospital and lowering drug use.[2] For patients with low back pain, OMT has also been shown to lead to lower medication use and less physical therapy.[3]

To paraphrase noted osteopath Dr. James Jealous, we osteopaths believe that the body has the innate capacity to heal and that it functions as a whole.[4] We use our hands to treat the whole patient and all levels of illness. We believe the autonomic nervous system plays a major role in disease and healing. At their best, osteopathy, OMM and OMT bring about an ease of motion, without tension, and with the capacity for change.

The founder of osteopathy, Dr. Andrew Taylor Still (see sidebar) asked that his students use their hands to "find the health" in their patients. In an osteopathic treatment, there is always some healthy, therapeutic process that can be found and potentially augmented, even when significant pain and disease are present. I often find myself telling patients that the hardest and best thing they can do is to get out of their own way. With osteopathy, I try to follow my own advice, nudging the anatomy in the right direction as precisely as possible, then getting out of the way to let my patient's body do the rest. ◇

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References

1. Jones JM, "Osteopathic Medicine," in Micozzi M, *Fundamentals of Complementary and Alternative Medicine,* Saunders (2010).
2. Noll DR, et al, "Clinical and research protocol for osteopathic manipulative treatment of elderly patients with pneumonia," *J Am Osteo Assoc,* 108:508-516 (2008).
3. Andersson GBJ, et al, "Comparison of osteopathic spinal manipulation with standard care for patients with low back pain," *NEJM,* 341:1426-31 (1999).
4. Jealous J, "Osteopathy is Service," www.jamesjealous.com.

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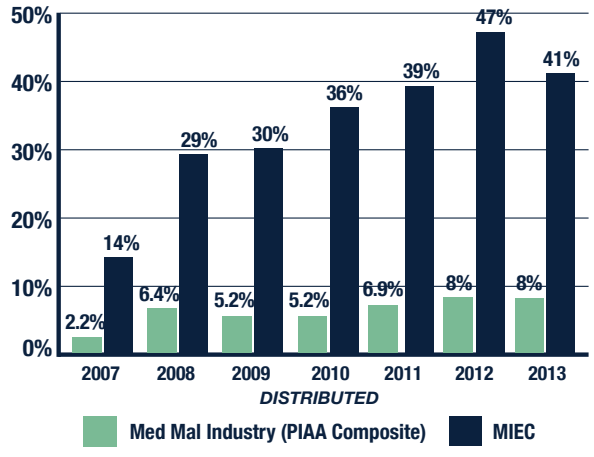

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Holistic Methods for Easing Depression

Molly Roberts, MD, MS

As a physician, you know how common it is to encounter patients with depression. In fact, emotional issues may be a significant factor in many of your patients' health concerns. Whether or not there are complicating medical issues, depression itself can leave your patient struggling to function in a grey fog of hopelessness and anxiety. Add another medical illness to the equation, and the healing process becomes much more complicated. It can become difficult to figure out how to help patients when both mind and body are affected.

Your patients are not alone—one in six people in the United States will experience some degree of depression or anxiety in their lives. Clinical depression is a severe and persistent condition that requires professional help, often in the form of prescription medications that can help lift the dark mood and correct chemical imbalances. But prescription medication is just one of many available treatment options for managing depression, and patients challenged by less severe emotional shifts may function well without a trip to the pharmacy. With or without chemical intervention, there's a lot your patient can do to battle the blues.

The main goal for your patient, and really for any of us, is to find joy, love, humor, meaning and connection in life. Blocks to happiness may be based in biochemistry, hormonal shifts, poor relationships, unhealthy perspectives, past traumas, other health concerns—the list goes on. Finding and addressing these causes while also building on what is functioning well in the individual is a recipe for success in the treatment of depression.

As an integrative medicine physician at the Sutter Pacific Medical Foundation's Institute for Health & Healing in Greenbrae, my approach allows me the time to understand the unique combination of physical, mental, emotional and spiritual aspects in a patient's life. In partnership with the patient, I find what will offer relief from the oppression of sadness while also empowering them to engage in their own healing.

My first step is to conduct a 60–90 minute assessment in a safe and nurturing environment to find the roots of complex health issues. This assessment builds upon the standard medical evaluation with an in-depth exploration of contributing factors, such as biochemistry, genetics, stress, sleep habits, diet, emotions, coping skills, meaning and purpose, and work and family life.

I then collaborate with the patient to develop a personal care plan that may include various lab tests, medications, herbs or supplements, along with the services of our other integrative specialists. Their services include psychotherapy, nutrition, acupuncture, Chinese medicine, chiropractic, craniosacral therapy, homeopathy, massage therapy, lymph drainage and bodywork. Our team acts as a bridge between allopathic and integrative approaches, with the recognition that these treatments can enhance each other if done well.

For depression, integrative psychotherapy seeks to explore and transform those limiting patterns, traumas and beliefs that may block or inhibit the patient. Approaches may include insight-oriented inquiry, lifestyle changes, eye movement desensitization and reprocessing (EMDR), emotional freedom technique (EFT), expressive arts, and guided imagery.

The Institute can bill PPO and POS insurance and Medicare for medical visits, acupuncture, chiropractic and integrative psychotherapy. Insurance plans may not cover all services, and they may have a cap on the number of allowed visits for some treatments, like acupuncture, chiropractic and psychotherapy. We strongly encourage patients to contact their insurance company to

Dr. Roberts, a family physician with additional training in integrative medicine and psychotherapy, is the lead physician at the Sutter Pacific Medical Foundation Institute for Health & Healing in Greenbrae.

Dr. Roberts (front) with Institute staff Al Wuthnow, CMT (retired) and Sharon Meyer, CNC.

learn about their plan, co-pays and whether they have met their annual deductible.

In any care plan, it is often worthwhile to start with the basics of self-care. Our team teaches patients healthy habits in order to help resolve issues that may be inhibiting their healing. Improved self-care benefits just about every aspect of a person's health and well-being. With mild episodes of depression, or as a complementary approach to the treatment of severe depression, we might suggest the following steps for self-care, all of which can be reinforced by an empathic practitioner.

Optimize your physical health

- Make sure you are eating a healthy diet to fuel your body properly.
- Get enough sleep for your body to rest and repair.
- Reduce stress chemicals in the body via exercise, relaxation techniques and massage.
- Move your body as much as possible with exercise, dancing or walks. This is even more important when feeling stressed but is often the first thing to go during rough times.
- Deal with chronic pain as effectively as possible and then relax into whatever pain remains.
- Use supplements as needed to offset deficiencies and support healing.

Optimize your emotional and spiritual health

- Dig into the feelings that may be behind the depressed state: guilt, traumas, anxiety.
- Connect with others: open up to a counselor, a trusted friend or a support group to help air those emotions that need release.
- Learn and practice a mind/body technique, such as mindfulness, meditation, prayer or biofeedback.
- Spend time in nature—a powerful mood lifter.
- Consciously increase the laughter and play in your life: watch comedies, play a game.
- Hug and smile as much as possible.
- Minimize depressive activities. Avoid TV news shows or serious dramas for a while to give your nervous system a rest.
- Help/give to others—a surprisingly successful way to feel good even if your own problems remain.
- Explore your own sense of purpose. Ask the big questions and see your life from a higher perspective.
- Expand your joy. Focus more on what makes you happy and lifts you up.
- Create something positive even in small ways: cook a good meal or decorate a corner in your home.
- Create a space in your home that is just for you, that is filled with mementoes and meaningful objects that remind you of what is important and joyful in your life. Inhabit that space regularly.
- Practice daily gratitude for the small or large parts of your life that you love.

Create community

- Find a supportive network of people. Reach out to family, current friends and acquaintances.
- If your community is small or nonexistent, build a new one. Consider taking a class, joining a volunteer group, softball league, spiritual community or other interest group.
- Instead of isolating, spend more time with others, even in small doses.

These subtle shifts in focus—from "what's wrong" to "what's right and what's possible"—can be powerful tools for lifting a patient out of a depressed state. With the guidance of an integrated team, your patients can have a role in their own healing, learning to practice and enjoy healthy habits to last a lifetime. Finding joy is worth the exploration. ◇

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For more information about the Institute for Health & Healing, or to make a referral, visit www.myhealthandhealing.org or call 415-461-9000.

The Most Powerful Treatment We Have

Robert Moore, MD, MPH

A primary care clinician recently diagnosed a patient with major depression and prescribed citalopram 20 mg per day. One month later, the patient felt less depressed. Her patient health questionnaire (PHQ-9) had dropped from 16 (moderately severe depression) to 12 (moderate depression). Since the patient was not in remission, the clinician increased the dose to 40 mg per day. One month later the PHQ-9 score was 8 (mild depression) and two months later, the score was 3 (minimal depression). Should the citalopram be continued? Which one of the following answers is most correct?

1. Yes. The citalopram worked and the patient is at risk of recurrence if the treatment is stopped.

2. Yes. Although the citalopram helped no better than placebo in this patient, stopping it will remove the placebo effect and increase the risk of recurrence.

3. No. The citalopram worked and remission is likely to continue without continued treatment.

4. No. The citalopram had no effect and the patient became better on her own, so continued treatment is not indicated.

Dr. Moore, a Napa family physician, is chief medical officer for Partnership HealthPlan of California.

I'll make it easier for you: 1 and 3 are incorrect. A 2008 meta-analysis demonstrated that antidepressants work well in severe depression (PHQ-9 score 20 or greater) but are no better than placebo for mild to moderate depression, as was the case in this patient.[1] Her improvement was not due to the pharmacology of citalopram. She might have improved without taking any pill, or she might have improved taking any pill she believed to be helpful. She's a classic example of the placebo effect.

We will return to this case at the end of this article. First, however, let's explore the implications of some new studies and thoughts on the placebo effect. All clinicians should have a mastery of the placebo effect, not for nefarious purposes (such as pushing sham treatments on patients), but to understand the natural history of disease and the role of the placebo effect in mainstream treatments that sometimes provide benefit.

History of placebo

The word *placebo* means "I shall please" in Latin. The term was used in the 14th Century to refer to sham mourners hired to sob and wail for the deceased at funerals. By 1785, it appeared in the *New Medical Dictionary,* referring to what were then considered marginal practices of medicine. In retrospect, we know that the efficacy of many treatments available at that time was due to the placebo effect. These included worm secretions for toothache (worked 68% of the time) and powdered Egyptian mummy (formerly available from Merck), which was used by President Lincoln's physician on the bullet wounds inflicted by John Wilkes Booth.[2]

The use of placebo in controlled clinical trials became common only in the last 50 years. In controlled trials, the "placebo effect" actually includes two effects: the effect of the natural history of the condition being studied (is it improved even if there is no treatment at all?) and the physiologic placebo effect (requires the patient's cognitive ability to understand what the treatment is attempting to do). The physiologic placebo effect is influenced by two factors: the expectation or belief that the intervention will work, and classical conditioning.

The power of belief

The strength of the placebo effect depends on the strength of the patient's belief that it will help. The placebo response in studies ranges from 0% to almost 100%, depending on the circumstances. Children tend to have greater responses than adults; patients with Alzheimer's progressively lose placebo responsiveness.

I would like to highlight five factors that increase the power of belief: (1) the invasiveness of the intervention, (2) the confidence of the prescriber, (3) the effect of advertising, (4) the cultural background of the patient, and (5) the price of the treatment.

No pain, no gain, part I. Cutting the skin has a powerful effect. From

1930 to 1955, internal mammary artery ligation was used to treat angina. Doctors opened the chest wall, tied off the internal mammary arteries, and closed the chest wall. Patients noted immediate relief that gradually decreased over time. In 1955, this treatment was compared to placebo: a sham surgery. With the patient put to sleep, the skin was cut and sutured, but the arteries were not ligated. The result rocked the medical world: there was no benefit of internal mammary artery ligation over sham surgery. Tens of thousands of individuals had endured open thoracic surgery for an ineffective treatment. The placebo effect was strong because of the invasiveness of the surgery, compounded by the certainty conveyed by the physicians (who really believed in it), and the high price for the surgery.

No pain, no gain, part II. Have we learned our lesson from the internal mammary artery example? Apparently not. How effective is viscosupplementation injection (using hyaluronic acid) of the knee for painful osteoarthritis? A 2012 meta-analysis of high-quality trials of intra-articular hyaluronic acid showed a clinically insignificant benefit over saline injection, and increased side effects.[3] Piercing a knee with a large needle and injecting a liquid works particularly well as a placebo. What is more interesting is the size of the placebo effect: 30–50% improvement in pain and 10–30% improvement in function. Finding the size of the placebo effect can sometimes be a challenge in reading scientific studies; they tend to focus on the "true" effect of the treatment, after adjusting out the placebo effect, even when the placebo effect is far greater in magnitude.

Is brand name really better? Many patients and even many clinicians believe brand name drugs work better than generic medications. Again, the belief of the patient impacts the strength of the placebo response. In a recent appeal process, a Partnership HealthPlan patient stated with great conviction that brand name Concerta helped his symptoms while the generic version did not work. Investigation showed that the same manufacturer produced both the brand name and the generic pills in the same factory, in the same way. The only difference: the brand name pills are labeled Concerta. Thinking through the implications, this patient should receive neither the brand name drug nor the placebo, because the entire benefit of the brand name appears due to its placebo effect, since the exact same medication, when generic, did not work. Please consider this every time a patient says the brand name works better: it is likely a placebo effect instead of a true difference in efficacy.

The effect of culture. Many studies have shown the placebo effect can be stronger in some cultures than others, depending on the condition. This circumstance is related to how people of different cultures experience illness and treatment. The placebo effect in treating gastric ulcers, for example, is low in Brazil, higher in Northern Europe, and extremely high in Germany.[4] However, the placebo effect in treating hypertension is lower in Germany than elsewhere.

The effect of price. People believe that higher cost medications work better. Most of us subconsciously use price as a surrogate indicator of quality. Taking this a step further, a higher price increases the belief a treatment will work and increases the strength of the placebo effect. This was best shown in a brilliant little study published in 2008.[5] Volunteers were recruited to study a "new" pain medication. Their baseline pain threshold was established with a series of electric shocks to the wrist. They were then divided into two groups. Each was given one of two identical placebo pills, with one group told this new treatment for pain would cost 10 cents per pill and the other told the treatment would cost $2.50 per pill. Pain was reduced by 55% in the low-price pill group and by 80% in the high-price pill group. Another key finding in this study was related to conditioning from prior use of pain medication, and will be described below. Before considering this, though, think through the implications of this study. What does it mean for a patient who requests a brand name medication, perhaps because of an advertisement seen on television? How should we clinicians interpret our patients' lack of response to low-cost generics?

The power of conditioning

The placebo effect in the pain pill study described above was stronger in patients with a history of chronic pain for which they had taken pain medication in the past. This result illustrates the effect of conditioning, the second factor contributing to the effectiveness of the placebo effect. It is well documented that in patients with chronic pain, their pain begins to subside when they know their pain medication is coming, before they even receive the medication. The end result is to reinforce the benefit of the pain medication (or placebo).

Conditioning can also affect prescribers! When multiple patients state with great conviction that the expensive brand name medication works better than the inexpensive generic equivalent, the clinician may start to believe this also and discount FDA studies showing bio-equivalence. Even worse, the clinician's belief can affect their prescribing pattern, leading them to initiate treatment with more expensive medications. It can also influence the degree to which they reassure their patients that the medication they prescribe will help them.

The overuse of expensive medications by prescribers because of conditioning leads to the important and disturbing conclusion that the placebo effect impacts not just the patient being treated, but also the clinician recommending the treatment. Here are some examples of the placebo effect on prescribers:

Antidepressants. Generic citalopram contains both the active levo-isomer and the inactive dextro-isomer of the medication. Brand name Lexapro contains only the levo-isomer. While there is a small possibility of an unfavorable side effect profile from the dextro-isomer, the presence of the

dextro-isomer should have no effect on the efficacy of the levo-isomer. If the levo-isomer dose is the same, the efficacy should be equivalent. Only the price and the brand designation could explain increased perceived efficacy.

Proton pump inhibitors. The effect of price and brand also applies to proton pump inhibitors. When prescribers select a more expensive agent like Nexium, they are not helping their patients, but only contributing to the high cost of healthcare. Brand name medications are on average about 15 times more expensive than equivalent generic medications.

Pain medications. Patients with chronic, non-malignant pain on greater than 120 mg of morphine per day will often develop more pain and request ever higher doses of narcotics. It is a vicious cycle, with higher doses temporarily alleviating pain. But with time, the pain becomes more severe and disabling. As narcotic overdoses have surpassed auto accidents as a cause of mortality in California in the last decade, the medical community is now aware of the danger high-dose narcotics pose for patients and the community, without really alleviating pain or improving function.

Counseling patients on this vicious cycle is difficult because of their belief in the power of narcotic medications, and because of the conditioning that changes the physiology of patients taking these medications chronically. The patient's belief is reinforced by withdrawal symptoms when a dose is missed or a clinician begins reducing the dose. Any drug with withdrawal symptoms will be harder for a patient to stop, because they often deeply believe that only that medication is actually controlling the disease. This is true of narcotic medications, benzodiazepine anxiolytics, many antidepressants, muscle relaxants, and even NSAIDs.

In all these cases, prolonged use of the medication produces long-term changes in the synapses. These changes cause patients to feel symptoms when the medication is withdrawn. Thus, withdrawal symptoms strengthen the

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placebo effect! In fact, if the patient can get through the withdrawal, they may feel the same or better than they did on chronic therapy—but it is hard to get the patient there. For this reason, physicians should wait until all other options are exhausted before initiating prolonged use of medications that can cause withdrawal symptoms.

Treatment effectiveness. When reviewing evidence for effectiveness of a given treatment, journal articles often compare only the effectiveness relative to placebo because this is the standard for FDA approval. I recommend always digging into the article to look at the treatment's effect on the control/placebo group, which can give valuable information. For example, early studies comparing amoxicillin to placebo for treatment of acute otitis media (AOM) in children showed the control group improved in 82% of cases (presumably most cases were viral and did not need antibiotics), while about 90% of the amoxicillin group improved.[6]

In the case of AOM, the mechanism of the placebo effect is not related to belief or conditioning, but on the natural course of the disease. Nonetheless, use of antibiotics in pediatric otalgia leads parents to expect antibiotics for treatment of all ear pain, since their child improved with treatment the last time antibiotics were prescribed.

Looking closely at the placebo effect in studies helps clinicians interpret marketing for new products. For example, should we preferentially prescribe a more expensive, more powerful antibiotic that is reported to improve 50% more cases of AOM than amoxicillin (i.e., a 12% benefit over placebo compared to 8%)? Perhaps we should just recommend ibuprofen for a few days (which would work 82% of the time) and reserve antibacterial treatment for cases where this conservative approach fails. This approach has been recommended by the American Academy of Pediatrics as an option since 2004,[7] but physicians have been slow to adopt it due to clinician conditioning.

Exploring alternatives

Adapting our clinical practice and communication with patients to account for the placebo effect may be the most important skill we develop. We must use our scientific training to inform the art of medicine. As clinicians, we owe it to our patients and society to account for the placebo effect and use only low-cost, relatively safe treatments when the major effect is likely to be placebo.

If the patient really wants a pill—when education about the nature of the condition doesn't seem to work—what should we do? Because it is ethically problematic to give a placebo treatment, clinicians tend to resort to medically acceptable treatments (especially pharmaceuticals), even if they know or strongly believe their benefit is most likely due to the placebo effect. One way around this conundrum is to consider lifestyle interventions. Examples include recommending gentle physical activity for low back strain, headaches or depression; working with the patient to make beneficial dietary changes for gastrointestinal symptoms, depression or anxiety; or recommending a low-cost multivitamin/mineral supplement to boost the immune system's ability to heal. If there is neither time nor resources for the more in-depth support required for dietary and physical activity changes, the vitamin option may be more attractive.

An important word of caution: the placebo effect does not prove that a serious condition is not present. Patients with life-threatening conditions may get some temporary relief from a placebo treatment, but the condition remains.

Going back to our original case of prescribing citalopram for moderate depression, the most correct answer is Option 4 (stopping the medication), which is also the most cost-effective option. Stopping the medication avoids escalation of treatments with no proven efficacy.

For the best option of all, based on an understanding of the placebo effect, consider trying non-pharmacological treatment, such as brief intervention counseling or cognitive behavioral therapy. ◇

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References

1. Fournier JC, et al, "Antidepressant drug effects and depression severity: a patient-level meta-analysis," *JAMA,* 303:47-53 (2010).
2. Ariely D, *Predictably Irrational: The Hidden Forces that Shape our Decisions,* Harper-Collins (2008).
3. Rutjes AW, et al, "Viscosupplementation for osteoarthritis of the knee: a systematic review and meta-analysis," *Ann Int Med,* 157:180-191 (2012).
4. Moerman DE, "Cultural variations in the placebo effect," *Med Anthro Quarterly,* 14:51-72 (2000).
5. Waber RL, et al, "Commercial features of placebo and therapeutic efficacy," *JAMA,* 299:1016-17 (2008).
6. Venekamp RP, et al, "Antibiotics for acute otitis media in children," Cochrane Database Syst Rev, 1:CD000219 (2013).
7. Lieberthal AS, et al, "Diagnosis and management of acute otitis media," *Pediatrics,* 131:e964-999 (2013).

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Stay Healthy!

Elson M. Haas, MD

After receiving my MD from the University of Michigan, and following an internship at Highland Hospital in Oakland, I began my own "country" practice in West Marin during 1974. My medical career has been quite an exciting journey, spanning four decades and integrating conventional Western medicine with natural, Oriental and preventive approaches. Throughout this evolution, I have practiced, written and taught about the evolving field of integrative healthcare.

Early in my medical career I realized that I wanted to do more than "treat symptoms"—I wanted to help people at the core of their health and healing. I felt it was important to learn how to motivate people to change habits and care for themselves in healthy ways. For this, I needed first to be my own patient, and to learn as much as possible about health and healing. So, I began studying about nutrition, herbal medicine, traditional Chinese medicine, fitness training, mind/body healing, and guided imagery. I worked with Marty Rossman, MD, in West Marin, where we practiced using varied healing approaches with our mentor Irving Oyle, DO.

During those early years, much of what I was learning and experiencing seemed important and useful. I became increasingly convinced that these traditional systems should be part of mainstream medicine, I told myself, because they seem to know much more about keeping people healthy than the conventional approaches that I learned in medical school. I also sensed that I needed these disciplines for myself as well as for my patients. As a result of these experiences and revelations, I began to write about all of these systems, integrating them into my practice and my first book, *Staying Healthy with the Seasons* (1981, 2004).

In 1982, I began calling my practice "integrated medicine," long before the term and the overall concept became popular. I used this term because I didn't believe the terms "alternative medicine" or "holistic medicine" truly captured the essence of this new field. I wasn't strictly "alternative" in my approach to healthcare, since I did use Western approaches when called for, such as ordering diagnostic testing and prescribing drugs. Likewise, I didn't feel that my practice was best defined as "holistic medicine" because that term was still quite vague, and it embraced many untested approaches.

In my view, bringing true integrative healthcare into the family practice setting—and coupling that care with education—was extremely important. This integrated approach has proven essential to helping people move from a "symptom fixing" model toward true preventive medicine and long-term sustainable health.

I am pleased to have been active in the forefront of this pioneering health movement back in the 1970s and early 1980s. The term for this field has circled back around to become known as "integrative holistic medicine," and it has its own board (see www.abihm.org).

How might we define the main features of Integrative Medicine (IM)? My own answer is to say that IM:

- **Blends family practice with health-supportive preventive medicine disciplines,** including prescriptive medicines (when needed), herbal and nutritional remedies, acupuncture, body therapies, and counseling/psychotherapy.
- **Takes a multidisciplinary approach to health** and uses a variety of medical approaches and services: Western and Eastern, natural and pharmaceutical, body therapies, and psychotherapy (mind/body/emotion integration).
- **Incorporates all levels of a person's life and lifestyle,** all as components of health, including mental, emotional, physical, spiritual, nutritional, habits, stress and genetics.
- **Uses a new approach** in treating symptoms and illness. Instead of merely asking, "What can I take to make this problem or symptom go away?" IM poses a new question: "**Why** do I have this problem or symptom in the first place?" IM moves from the "attack and conquer" approach to the idea that problems represent conflicts within us, while health involves re-integration and healing of unresolved issues, conflicts and emotions. IM ideally looks at

Dr. Haas, founder and director of the Preventive Medical Center of Marin in San Rafael, is the author of Staying Healthy with Nutrition, The Detox Diet, *and* Staying Healthy with the Seasons.

underlying causes and addresses them at their source.

After years of testing and refining my own form of IM, I have observed, learned, and now believe that most causes of ill health have their roots in our lifestyle. With this, I employ four principles that I think are basically good common sense:

• **How we look and how we feel are primarily based on how we live:** what we **eat,** whether we **exercise** and stay fit, how we **sleep,** how well we manage **stress,** and our overall **attitude,** which also affects how we apply the other aspects of a healthy lifestyle. I call these the "five keys to staying healthy."

• **Health is feeling good and having energy and vitality** for life without many symptoms or medical issues, although of course, we can have medical problems and still feel healthy.

• If we want to feel healthier in many ways, **we need to change how we live.** Most often, different actions will create different results, whether it's related to blood pressure and cholesterol levels or getting sick easily or not.

• My therapeutic approach is **Lifestyle first, Natural Therapies next, and Drugs last.** This is almost the reverse of the approach taken in modern Western medicine, where drugs are often the first choice of doctors to treat patients, and natural and lifestyle approaches are often given less priority.

Entering my fifth decade of practice as a physician, I am focusing more on the process by which I—and others—might spread awareness of the true power of integrative healthcare to the medical community and to the population of those who need true healing and care. How can we all work together to change and improve healthcare, which to me means keeping both our selves and our patients healthy?

It's important for all health practitioners to know and apply more in regard to lifestyle and to be **educators,** which relates to the core Latin meaning of the word *doctor.* That word comes from *docere,* meaning "to teach." My hope is that future primary care practices will be given the respect they have earned and deserve in the medical community, and that primary care providers can afford **staff to support and motivate patients to make positive lifestyle adaptations.** I also believe that **patients need to take more personal responsibility for their own health.** Self-reliance is crucial to attaining and maintaining good health. This also should go along with some greater financial responsibility in that somehow we find a way to build in more rewards and penalties for the way we take care of ourselves as individuals.

The practice of medicine is always evolving, and in many respects we are also at a crossroads today in terms of the future of our healthcare system and the quality of affordable care and education we provide to our citizens. To be sure, we have made great strides in the past 40 years, with improvements in technology for testing and treatment, vaccines and surgical procedures—all of which have proved to be amazing in helping us handle many health problems. Yet, keeping people healthy before they need such medical advances is ultimately the best form of healthcare, and in my opinion should be foremost in our minds, hearts and practices.

In the years ahead, I plan to continue to learn while I teach about integrative healthcare. In other words, some goals include: **Doctors as teachers; patients as doctors; and the staff as a support for the health of doctors, patients, and the practice.** It can all work. I am so happy to be part of the integrative medicine approach in helping my patients stay healthy.

That's my personal motto: "Stay Healthy." My practice motto might be: "Your health starts with you!" ◇

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Wayne County, MI	$121,321	$35,139	$108,020	$88,160
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Multidisciplinary Treatments for Fibromyalgia

Paul Davidson, MD, FACR

My interest in fibromyalgia syndrome (FMS) began when I was a fellow at the Mayo Clinic training in internal medicine and rheumatology from 1957 to 1960. At that time FMS was generally known as fibrositis, but the syndrome was later named fibromyalgia because of the lack of any findings of inflammation. Most physicians at the time (and many to this date) considered it a "wastebasket diagnosis."

My perspective is that FMS is not really a disease (manifested by both signs and symptoms), but rather a somatoform disorder (manifested only by symptoms). As of this writing, there are no physical or laboratory findings that allow us to make a firm diagnosis of FMS. The syndrome is diagnosed almost entirely by symptoms and a tender-point examination, which is often inconsistent. Whatever you wish to call FMS—a disease, a somatoform disorder or a psychosomatic disorder—it can vary from a mild to a very debilitating condition. Empathetic physicians can be quite helpful in treating this enigmatic disorder.

Let me address some basic questions regarding FMS.

What are the symptoms of FMS?

A typical case may be illuminating. The patient, BJ, was a 26-year-old newly married secretary working in a law firm. She complained of generalized muscle pains and stiffness, neck and low back pain, chronic fatigue, poor sleep, paresthesias, headaches, frequent urination, and irritable bowel symptoms—all increasing for the past six months. She was depressed and anxious "because of my pain." She had formerly been a trainer at a gym but was now working hard in the law office for up to 50 hours a week. She had no time to get any significant exercise.

BJ had an extensive workup with her internist, including a history, a physical exam, an arthritis panel, muscle enzymes, thyroid studies, Lyme and parvovirus titers, and MRIs of the cervical and lumbar spines. The results were all negative, except for a minimally positive RA factor and normal ESR and anti-CCP tests. She seemed unusually tender in many body points, but her muscle strength was good.

She was referred to specialists in neurology, neurosurgery, gastroenterology, endocrinology, urology and rheumatology. None found any pathology to account for her symptoms. Despite the lack of any joint swelling, the rheumatologist's diagnosis was "probable early rheumatoid arthritis." She was treated with Plaquenil, NSAIDs, analgesics, muscle relaxants, antidepressants, narcotics and even a brief course of prednisone. She did not improve. In fact, she felt worse.

BJ's first physical therapy visit increased her pain, and she had to go to bed for three days. Her medical bills were mounting; she took more time off work; she was getting depressed; she asked to be put on disability. Meanwhile, her internist was becoming very, very frustrated. Her pains were considered to be an "industrial injury" and were reported as such. Her internist then became embroiled in an endless round of paperwork with the workers' comp carrier and her attorney. The internist's thoughts began drifting to taking a long vacation in Hawaii. Spurred by these thoughts, he got another rheumatology opinion.

The second rheumatologist got more history from BJ and learned that she hated her boss and her job. She had no time to exercise. Her major concerns, beside her symptoms, were the specter of permanent disability and the effects on her marriage. Her joint examination was normal. Her new diagnosis was classical and early FMS. She was given information on FMS and a two-month medical leave from work. She was also told to stop all medications, gradually get back to her previous exercises, and return in a month.

BJ called back three weeks later, laughing, and cancelled the appointment. Asked why, she said she was back to normal, had quit her job, was getting more exercise and might go back to being a physical trainer.

BJ's case is illustrative in many aspects. First, the excessive number of referrals to other physicians and the delay in diagnosis is not unusual. Second, not getting a history of her lack of exercise and the stress of her work situation played major roles in the de-

Dr. Davidson, a retired rheumatologist, is the author of Chronic Muscle Pain Syndrome, *a bestselling book on fibromyalgia.*

lay in diagnosis. Third, her unusually rapid recovery was most surely due to her understanding of the basis of her illness plus the resolution of her legitimate concerns regarding chronic disability and the subsequent strains on her marriage.

Who is best qualified to diagnose FMS?

Any physician who has a basic knowledge of the symptoms of FMS and is a good listener should do fine, whether it's a family physician, an internist or a rheumatologist. A referral to a rheumatologist can be helpful if the primary care physician is concerned about another disorder, such as rheumatoid arthritis, lupus, polymyalgia rheumatica or Lyme disease. If the rheumatologist does not "believe" in FMS, avoid him or her. Too often, the non-believer will not recognize FMS developing in a patient with an associated rheumatic disease and will treat every symptom with potent medications that can make things worse.

Who is best qualified to treat FMS?

I firmly believe that a family physician or internist who has the disposition to work with the patient could do as well or better than a rheumatologist. The primary care physicians probably have a better understanding than the specialist of the total physical and emotional state of the patient.

What are the treatments for FMS?

A multidisciplinary approach to treatment has been the most effective and is now generally accepted. In my book *Chronic Muscle Pain Syndrome* (1989), I advocated a program that I named RETRAIN, as summarized below.

R is for Rest and Relaxation. Most FMS patients are under stress from a number of causes, such as family, work and poor health. The method of R&R (they are two different things) will depend on understanding what stresses exist.

E is for Education. There are many good (and bad) basic books and articles that can offer the patient understanding and guidance. My guideline is that if a patient feels worse after reading certain information, they should ignore it. The same goes for support groups. Some are excellent. Others, as one patient told me, are just "pity parties" and should be avoided.

T is for Therapeutic Muscle Training. Many studies have shown that the muscles are normal in FMS. A good physical therapist can guide a patient through exercises that start slowly and gradually increase without creating additional discomfort.

R is for Responding to Stress. First, the origins of the stress must be uncovered, since the patient may be unaware of the origins or loath to discuss them with you. If the patient is not responding, a referral to a psychologist or psychiatrist is probably in order. Psychotherapy or cognitive behavioral therapy may be of benefit and can serve as a key to improvement.

A is for Analgesics and Other Medications. Medications such as acetaminophen and NSAIDs generally do not help FMS, and narcotics should be avoided. Trazodone or amitriptyline (may cause weight gain) in small doses at bedtime should be the first choice since they have relatively few side effects and are inexpensive. A host of other medications have also been used for FMS, the most popular being the SSRIs and the SSNRIs. They are more expensive and generally have more side effects, including weight gain. In my experience, the incidence of positive results is pretty similar with all of these medications—about 30%.

I is for Involvement and Alternative Therapies. If the patient is not personally involved in his or her therapy, you are probably fighting a losing battle. Many alternative therapies can be very helpful and do not require a doctor's prescription. Choices include tai chi, Feldenkrais, yoga and meditation. See the sidebar for more information on tai chi, which has become one of my favorite alternative movement therapies.

N is for Never Give Up Hope. No matter how severe your patients' symptoms are, there are many paths to relief. Many patients have informed me that their FMS is "cured," despite some naysayers who are convinced that it never goes away. If these patients have no symptoms, they are presumably cured. You may find that your FMS patients are some of the most grateful in your practice! ◇

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Tai Chi for Fibromyalgia

Tai chi is a Chinese body-mind movement exercise based on the martial arts that goes back hundreds of years. Research has shown that it promotes balance control, flexibility and cardiovascular fitness. It also lessens the risk of falls in elderly patients and in those recovering from stroke and other conditions. According to estimates, Tai chi's gentle, low-impact movements burn more calories than surfing and nearly as many as downhill skiing.

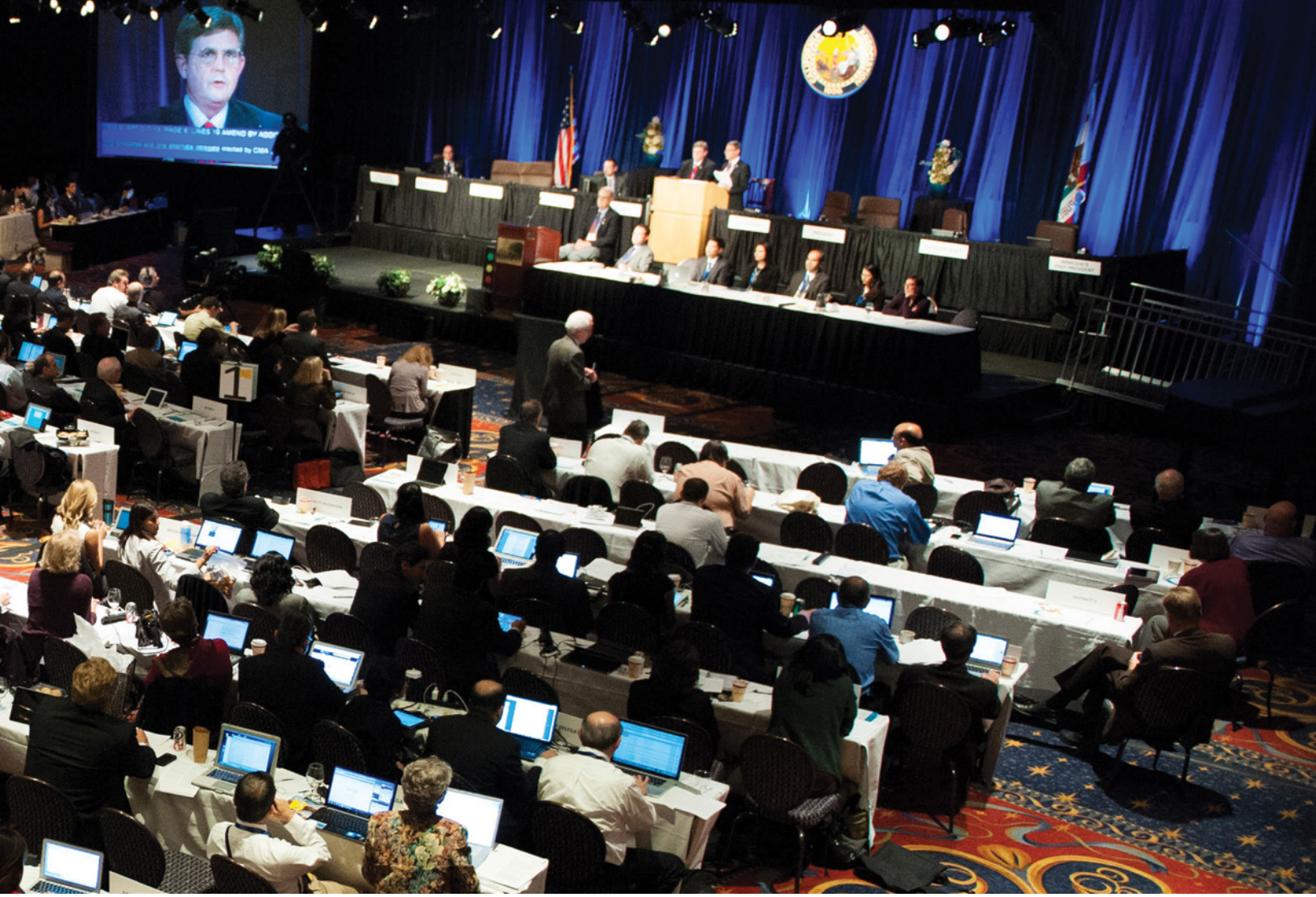
A recent study published in the *New England Journal of Medicine* found that "tai chi may be a useful treatment in the multidisciplinary management of fibromyalgia. Longer-term studies involving larger clinical samples are warranted." [Wang C, et al, "A randomized trial of tai chi for fibromyalgia," *NEJM*, 363:743-754 (2010).]

In my opinion—which is probably shared by many millions of people around the world—I doubt if further studies of tai chi are needed before trying the technique. Tai chi has been shown over the centuries to be helpful in many patients, so why not just try it? It is non-invasive and harmless, with no apparent side effects, and the cost to learn is relatively inexpensive compared to the cost of many medications.

The most popular form of tai chi is the Yang style. YouTube has many great videos of this particular style; they are a pleasure just to watch. A superb and widely available DVD is "Simplified Tai Chi Chuan" by Master Shou-Yu Liang.

HOD 2013

CMA delegates set policy at annual meeting



More than 500 California physicians convened in Anaheim Oct. 11–13 for the 2013 House of Delegates (HOD), the annual meeting of the California Medical Association (CMA). Each year, physicians from all 53 California counties, representing all modes of practice, meet to discuss issues related to healthcare policy, medicine and patient care, and to elect CMA officers.

Over 90 resolutions were introduced and debated in reference committees on Friday, Oct. 11. Over the next two days, the complete HOD met again to debate and vote on reference committee recommendations. Sixty-three resolutions were adopted.

As a first step toward a "virtual" reference committee process that will enable a shorter, two-day meeting in future years, Reference Committee A (Science and Public Health) conducted all testimony online in advance of the meeting. All CMA members were invited to participate in the debate, and nearly 300 online comments were recorded. The committee members then met via web conference in advance of the meeting to develop their recommendations, which were presented to the HOD for floor debate on Saturday afternoon.

The HOD also elected a new president, Paradise internist Richard Thorp, MD. Humboldt surgeon Luther Cobb, MD, was tapped as president-elect.

Summaries of some of the resolutions that were adopted as policy appear on the following pages. The full actions of the HOD are available to members at www.cmanet.org/hod, under the Documents tab.

House of Delegates 2013

Increased reporting of immunizations

Resolution 104-13

The delegates approved a resolution that encourages increased reporting of patient immunizations to the California Department of Public Health for purposes of vaccination, disease control and prevention.

HIV and STDs: Consent requirements for testing

Resolution 109-13

The delegates voted to support revision of HIV consent requirements to allow all healthcare providers to order a test for HIV when appropriate and to encourage routine HIV testing for all patients who are evaluated for other sexually transmitted diseases.

Graphic health warnings on tobacco products

Resolution 115-13

Delegates called on CMA to support the use of graphic image labeling on cigarette and other tobacco packaging that warns of the health impact of smoking.

Legal blood alcohol limit for drivers

Resolution 118-13

Delegates endorsed the National Transportation Safety Board's 2013 recommendation that the legal blood alcohol limit for operating a motor vehicle be decreased from .08% to .05% or lower.

MMS delegate Dr. Peter Bretan testifying at the HOD.

Food insecurity screening

Resolution 122-13

The delegates directed CMA to promote that providers need to identify children and adults who are food insecure to avoid detrimental development and comorbidities and to refer them to appropriate programs and services.

Elimination of CMS outpatient observation status

Resolution 211-13

The delegates directed CMA to request that the Centers for Medicare and Medicaid Services (CMS) eliminate its "outpatient patient observation" status, which is placed upon patients whose anticipated hospital stay is 48 hours or less. Delegates noted that this practice places undue financial burden on patients and creates administrative hassles for physicians.

Health exchange benefit designs and tax deductibility of out-of-pocket expenses

Resolution 401-13

The delegates called on CMA to support efforts to develop benefit designs in the health benefit exchange that appeal to the young and healthy to boost the risk pool; and to support legislation allowing federal and state income tax deductibility of all out-of-pocket healthcare expenses.

Reimbursement for telephone/electronic patient management

Resolution 407-13

The delegates asked that CMA support legislation requiring health insurance companies to pay physicians for telephone or other electronic patient management services.

National health information exchange

Resolution 501-13

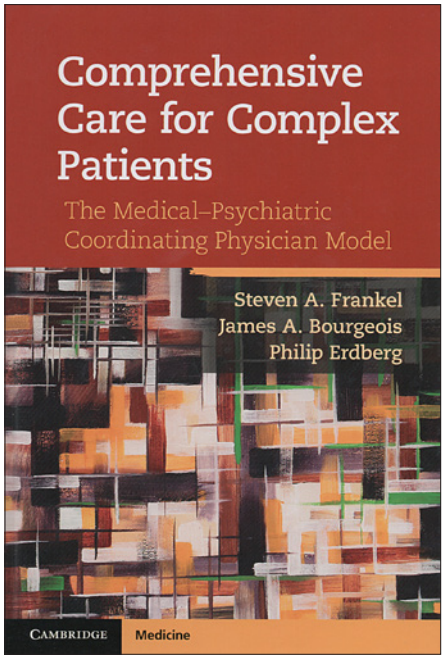
The delegates called on CMA to support the development of a secure, interoperable, nationwide health information exchange network.

Detailed descriptions of selected resolutions appear on pages 30 and 32.

Marrying Medicine and Psychiatry

Scott Barshack, MD

Comprehensive Care for Complex Patients: The Medical-Psychiatric Coordinating Physician Model, by Steven Frankel, MD, James Bourgeois, OD, MD, and Philip Erdberg, PhD, Cambridge University Press, 201 pages (2013).



Traditionally, when a patient was referred to a psychiatrist, he or she would disappear into a great void, where no one except the psychiatrist and the patient would know what was transpiring. Primary care physicians would typically rely on the patient to find out such things as the psychiatric diagnosis and the medications that were prescribed.

If the authors of *Comprehensive Care for Complex Patients* had their way, the psychiatrist would be forced out of this disappearing act and into a key role as the coordinator of care for "complex" patients with multiple comorbidities. The authors—two local psychiatrists and a psychologist—describe this new type of psychiatrist as an MPCP: a medical-psychiatric coordinating physician. They acknowledge that MPCPs would need additional training in medical areas, possibly through a post-residency fellowship. In their view, MPCPs would be instrumental in managing the care of those 10% of patients who demand up to 70% of a primary care physician's time. They further posit that it makes sense for psychiatrists to assume the MPCP role because many of these complex patients have a mixture of medical and psychological issues, with one affecting the other.

Through exhaustive research (there are nine pages of references), the authors lay out a convincing argument for having a key person, the MPCP, coordinating care. They clearly demonstrate that many things are missed when one does not conduct a thorough initial evaluation, including interviewing the patient, family members, and past and present medical providers, as well as laboratory testing, scans, and psychometric testing.

At times, I found the book to be a bit heavy in introducing new terms, and it is also somewhat repetitive. Nonetheless, it is an easy read that can be finished in one sitting. The case studies are particularly helpful and entertaining. In these studies, physicians will readily recognize that we all have treated patients like this, usually ineffectively. Adopting the MPCP model would definitely serve these patients better.

Besides advocating collaboration with the primary care physician and other specialists, non-MD providers and family members, the MPCP model advocates "truing" as a method of improving care. I was not familiar with this term. When the authors described it in mathematical terms and likened it to approximating the asymptote, I began to understand it better—through gathering further history, interviewing family members, and performing psychological and lab testing, the clinician is always revising his assessment and treatment plan.

Of course, this is the way we all try to practice medicine, but often due to time constraints, we fall short. In fact, if I had one criticism of the MPCP model, it would be just that: Who has the time to treat these patients so exhaustively? If I served the MPCP role, I probably would have to cap myself at about 20 total patients.

The question of time brings up another issue regarding the MPCP model: Is it cost-effective? One could argue that by coordinating care with just one "point person," we are cutting down on redundancy and freeing up the time of the collaborating physicians and possibly catching severe diseases in an earlier phase. However, at what expense? I could see the physician who signs up for the MPCP role spending several hours collaborating with other providers for every one hour he meets with the patient.

I started my private practice in psychiatry at the same time that managed care arrived. I was quickly shuttled into the role of medication management and more or less restricted from performing

Dr. Barshack, a psychiatrist in private practice in Corte Madera and Petaluma, served as medical director of psychiatry at Marin General Hospital from 1995 to 2010.

CMA HOUSE OF DELEGATES

Delegates push for increased reporting of immunizations

The CMA House of Delegates passed a resolution directing the association to encourage and promote the reporting of immunizations to the California Department of Public Health for purposes of vaccination, disease control and prevention (Res. 104-13).

"More accurate tracking of immunizations would lead to improved vaccination rates, reduce duplicative health services and improve the health of all Californians," wrote one delegate in online testimony.

Nearly one in four children sees more than one immunization provider by age two. In fact, the chart in the child's most recent medical home is accurate only 62% of the time.

With increased reporting, public health departments can better identify people who are at risk in the event of a disease outbreak or other emergency such as hurricanes, earthquakes, floods or man-made disasters. They can also help locate communities with low coverage rates so that they can provide targeted interventions to increase coverage rates and protect more people from disease.

CMA supports reduced blood alcohol limit for drivers

The CMA House of Delegates voted to endorse the National Transportation Safety Board's 2013 recommendation that the legal blood alcohol limit for operating a motor vehicle be decreased from .08% to .05% or lower (Res. 118-13).

According to the National Transportation Safety Board (NTSB), each year in the United States, nearly 10,000 people are killed in crashes involving alcohol-impaired drivers and more than 173,000 are injured, with 27,000 suffering incapacitating injuries. Since the mid-1990s, even as total highway fatalities have fallen, the proportion of deaths from accidents involving an alcohol-impaired driver has remained constant at around 30%.

Research shows that although impairment begins with the first drink, by .05% blood alcohol content most drivers experience a decline in both cognitive and visual functions, which significantly increases the risk of a serious crash. Currently, over 100 countries on six continents have limits set at .05% or lower. The NTSB has asked all 50 states to do the same.

CMA supports graphic image labeling on cigarettes

The CMA House of Delegates overwhelmingly voted to support graphic image warning labels on tobacco packaging that depict the very real health impact of smoking (Res. 115-13).

The U.S. Centers for Disease Control and Prevention rolled out a series of graphic advertisements in 2012, which featured startling photos of the health consequences of smoking. National smoking cessation hotlines and websites saw a doubling of calls and a fivefold increase in web visits while the ads were running.

The United States Food and Drug Administration has also proposed placing such images on cigarette packaging as a deterrent to smoking and a stimulus to cessation, but was stopped by legal challenges from the tobacco industry.

The resolution also directs CMA to urge courts to also support such labeling.

"Family physicians support the required use of graphic warnings and statements on cigarette packages and advertisements as an important step toward reducing the existing and future use of tobacco products," wrote one delegate in online testimony. "Warnings help counter the $12.5 billion cigarette manufacturers spend marketing their products each year. More than two dozen countries already require similar packaging for cigarettes."

psychotherapy. Why pay a psychiatrist $100 an hour (back in 1990) to perform psychotherapy when an LCSW or MFCC would do it for $50?

Given these realities, I can only see the MPCP model working in two scenarios: (1) the MPCP doesn't mind making much less money and not getting reimbursed for time spent outside of the therapy hour, and (2) charging patients and their family privately. The latter may prove difficult because complex patients often end up on disability and/or public assistance. Unfortunately, the authors dedicate only a few pages to the issues of cost.

On the other hand, the authors have completed a pilot study of 52 patients who have been in the MPCP system. As a next step, they are going to compare patients treated with MPCP to those treated with other modalities. I look forward to seeing the results of their research.

In summary, the authors make a convincing argument through extensive research and case studies that the MPCP model would greatly improve the care of the most difficult-to-treat patients. Where and how this model can fit into medicine in 2013 and going forward with Obamacare remains to be seen.

While I doubt that I will incorporate everything this book suggests into my own practice and become an MPCP provider, I will certainly use some of its main suggestions: conducting a thorough initial interview; coming up with a treatment plan; constantly revising that plan based on new information gathered; and seeking out collateral information from key players in the patient's life. I will also make a more sincere attempt to keep the primary care physician in the loop.

Psychiatrists who see complex patients will probably find this book helpful. Primary care providers may also enjoy reading it and learning to incorporate some of these same techniques into their practice. ◇

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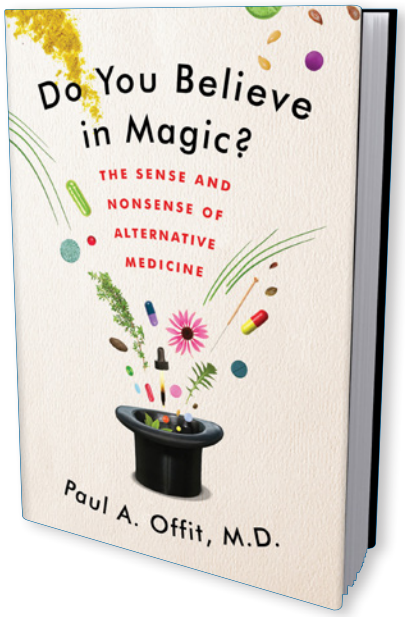
Separating Fact and Fiction

Irina deFischer, MD

Do You Believe in Magic?: The Sense and Nonsense of Alternative Medicine, by Paul Offit, MD, HarperCollins, 341 pages (2013).



Paul Offit, MD, is a pediatrician and infectious-disease specialist in Philadelphia who is an expert on vaccines, immunology and virology. He is the co-inventor of the rotavirus vaccine, for which he has received wide recognition. He also received death threats after publishing his previous books: *Autism's False Prophets: Bad Science, Risky Medicine, and the Search for a Cure* and *Deadly Choices: How the Anti-Vaccine Movement Threatens Us All.* In his well-written and thoroughly researched new book, *Do You Believe in Magic?,* he examines the scientific evidence pertaining to popular complementary and alternative remedies, and he details their risks and benefits.

In the mid-18th century, the French philosopher Voltaire wrote, "The art of medicine consists in amusing the patient while nature cures the disease." At that time, Western medicine consisted largely of bloodletting. Fortunately, the science of medicine has made significant advances in the last 250 years, yet many patients choose to forego these advances in favor of centuries-old therapies. What makes these patients so leery of modern medicine, and so willing to turn to unproven, unregulated treatments?

"There's no such thing as alternative medicine," writes Offit. "There's only medicine that works and medicine that doesn't." He maintains that medicines touted as natural should be subject to the same rigorous testing as mainstream medicine. In the book's introduction, he tells the story of the unfortunate Joey Hoffbauer, a child from New York who was diagnosed with lymphoma in 1977. Though radiation and chemotherapy would have given him a 95% chance of cure, Joey's parents were concerned about potential side effects and decided instead to entrust his care to Dr. Michael Schachter, a psychiatrist with no experience in cancer treatment.

Schachter prescribed Joey a regimen of laetrile, derived from apricot pits, as well as raw milk, raw liver juice, cod liver oil, soft boiled eggs, coffee enemas, and a number of other remedies that had not been approved for use in humans. After a court battle in which the Department of Social Services tried to remove Joey from his parents so he could receive conventional therapy, the judge ruled against the cancer specialists and in favor of Joey's parents. Though Joey succumbed to his illness three years later, Schachter declared the treatment successful, stating, "Most of his body was either free of Hodgkin's or minimally involved." Further studies showed that laetrile was of no substantive use in the treatment of cancer, and the FDA banned its sale in 1987. It can still be obtained from clinics in Mexico, however.

In a chapter called "Rediscovering the Past," Offit takes on celebrity physicians—such as Drs. Mehmet Oz, Andrew Weil and Deepak Chopra—who promote traditional therapies based on the notion that supernatural forces cause diseases and maintain that acupuncture, plants, herbs, oils and spices will balance humors and restore energies. Offit also explains the theory of homeopathy, i.e., that medicines should induce the same symptoms as the disease. In order to prevent harm, however, homeopathic medicines are diluted to the point that the active ingredients are no longer detectable.

Further on, Offit tells the story of how the father of chiropractic medicine, Dr. D.D. Palmer—a mesmerist who used magnets to treat his patients—claimed that by adjusting the cervical spine to treat subluxation he was able to cure a man of deafness. (This is curious given that the eighth cranial nerve, which connects the ear to the brain, doesn't pass through the cervical spine.)

Offit goes on to critique the vitamin

Dr. deFischer, a Petaluma family physician and geriatrician, is president of MMS.

industry and its powerful lobby, the National Health Federation (NHF). He describes Nobel laureate Linus Pauling's claims that vitamin C not only prevents colds but also cures cancer and many other ailments—claims that were later disproven. Lack of scientific evidence, however, failed to deter Pauling and his followers from touting the benefits of vitamin C and other megavitamin supplements. Despite several randomized controlled studies showing that patients who take megadoses of vitamins not only don't benefit but are actually more likely to die of cancer, most Americans are unaware that the supplements they take may be harmful.

The establishment of the FDA in 1906 was the first attempt to ensure food and medication safety, writes Offit. In 1938, the FDA began to require testing of drugs for safety prior to their sale. But the 1975 Proxmire amendment categorized vitamins and supplements as foods, thereby exempting them from FDA oversight as pharmaceuticals, in the name of freedom of choice for consumers. In 1994 the FDA's authority over "natural" products was further eroded by the Dietary Supplement Health and Education Act, which effectively created a third class, neither food nor drug, but "dietary supplement." The *New York Times* called the new law the "Snake Oil Protection Act."

In subsequent chapters, Offit decries celebrities Suzanne Somers and Jenny McCarthy as spokespersons for anti-aging potions and autism, respectively, as well as the politics of chronic Lyme disease and alternative cancer cures.

In the chapter "Why Some Alternative Therapies Really Do Work," Offit examines the effectiveness of therapies such as acupuncture. He attributes their success to the powerful placebo effect mediated by the release of the patient's own endorphins in response to the intervention.

Offit cautions readers to beware of quackery, which he defines as recommending against conventional therapies that are helpful, promoting potentially harmful therapies without warning, draining patients' financial resources, and promoting magical thinking. He ends the book with a story about Dr. Albert Schweitzer and a witch doctor in Gabon. The witch doctor has three types of patients. The first group, those with minor illnesses that will resolve on their own, he treats with herbs. The second group, those with psychological problems, he treats with incantations. The third group, those with diseases or injuries only modern medicine can treat, he refers to Dr. Schweitzer.

I recommend *Do You Believe in Magic?* for anyone with an interest in alternative medicine—whether you use it yourself or want to discuss pros and cons with your patients. ◇

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CMA HOUSE OF DELEGATES

Delegates weigh in on exchange grace period

Members of the CMA House of Delegates took a stance on the 90-day grace period provision called for in the Affordable Care Act (ACA), an issue that has been rapidly evolving in response to CMA's continued advocacy.

The resolution (Res. 402-13) was amended by delegates during floor debate to reflect recent state and federal actions regarding the grace period provision. The resolution, as adopted by the House, calls for heightened standards for information provided to physicians regarding enrollees in the state's health benefit exchange, as well as a provision emphasizing CMA's position that physicians should not be compelled by payors to participate in exchange products.

As initially proposed, the ACA's grace period posed considerable risk to physicians participating in exchange products, potentially exposing them to two months of suspended and/or denied claims if a patient is delinquent on their insurance premiums. Recently, however, California's Department of Managed Health Care has asserted that patients falling under the grace period provision would have coverage suspended after the first 30 days, and that insurance companies could not represent this coverage as active to the participating physician. The patient would then have the second and third months to pay the premium balance and have coverage reinstated.

Marin Community Clinics

Georgianna Farren, MD

Like many healthcare organizations throughout the country, Marin Community Clinics (MCC) is in a state of transformation. For several months, we have focused a lot of energy on achieving recognition as a patient-centered medical home (PCMH) through the National Committee for Quality Assurance (NCQA), which offers three levels of PCMH recognition. We are proud to announce that we've attained PCMH Level 1 status for our San Rafael and Novato clinics, putting us in an elite group of healthcare providers and clinics.

The NCQA seal is widely recognized as a symbol of quality, and achieving Level 1 recognition indicates that an organization has attained a high level of quality care and service. We are now applying for Level 1 recognition for our clinics in Greenbrae and at the Marin Health and Wellness Campus in San Rafael, and we are working toward Level 3 recognition (the highest level) for all four locations.

Why would a busy community clinic choose to become a PCMH? Because PCMH transforms the practice from traditional primary care to a model that enhances access and continuity for patients. Within the PCMH framework, there is a partnership between patients, clinicians and staff. Appointments are more readily available, and care is coordinated with outside agencies when needed. There is also dedication to continuous quality improvement, using evidence-based guidelines and shared decision-making between patients and clinicians. The PCMH model requires embracing a patient-centered approach in access, care and continuity. Patients choose a primary care provider and become familiar with the team that shares their care.

The PCMH approach supports our mission to improve the health of our patients and community by providing high quality, cost-effective, culturally sensitive, patient-centered health care. We are on track to complete the application process for Level 3 recognition in June 2014. As part of this effort, we are piloting a patient portal and focusing on continuous improvement in appointment and telephone access.

MCC provides primary care services in pediatrics, adult and family medicine, dental health, behavioral health, obstetrics and gynecology, teen clinics, and pharmacy services. In our efforts to expand patient services, we recently added optometry at our Novato and San Rafael clinics in collaboration with the School of Optometry at UC Berkeley. This service has been incredibly popular for adult and pediatric patients, and in January, optometry services in Novato will grow from two to five days a week.

Another element of transformation is coming from Carebook, a collaborative program with Marin General Hospital intended to improve patient care during transitions from the hospital. Carebook allows nurses, clinicians and social workers to communicate during the discharge process. MCC team members in Greenbrae check Carebook online daily to see who needs a hospital follow-up appointment. Once the follow-up appointment is made for one of our patients, the time and details are communicated back to hospital staff. Three days per week, one of our staff goes to the hospital to ensure that patients know the date and time of the hospital follow-up appointment. As a result, patients benefit from improved continuity of care between Marin General and MCC.

Since its inception over 40 years ago, MCC has been a healthcare provider to thousands of Marin residents with limited options, primarily to patients who are uninsured or are Medi-Cal beneficiaries. With full implementation of the Affordable Care Act in January 2014, many of our patients will have more insurance options. Medi-Cal will also be expanded so that many people who are not currently eligible will qualify for benefits. Many others who are currently uninsured will be able to purchase insurance through the Covered California Health Insurance Marketplace.

Each MCC location has certified educators and enrollment counselors available to help patients make informed decisions about their health insurance coverage and to assist with enrollment. We are pleased that up to 4,000 of our 31,000 patients will become insured at the start of 2014. ◇

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As MICRA Threat Reemerges, Physicians Stand to Defend the Law

Richard Thorp, MD

When trial lawyers announced earlier this year that they were working to scrap California's Medical Injury Compensation Reform Act (MICRA), the California Medical Association (CMA) warned that the campaign would be riddled with lies, misdirection and below-the-belt shots designed to fool the public into thinking the trial lawyers' efforts were anything more than an outright money grab.

Unfortunately, we didn't know how right that warning would prove to be.

Since its passage, MICRA has been under near-constant attack from those who place the prospect of a higher payday above the overall health and well-being of California residents. While MICRA has repeatedly weathered the storm, the law is under siege once again. This time MICRA is facing the greatest threat yet, as trial lawyers aim to put more money in their own pockets at the expense of patients across the state.

Driven by greed and the promise of inflated attorney fees, California trial lawyers have renewed their fight to lift MICRA's cap on speculative, non-economic damages, presenting ballot language that seeks to more than quadruple the maximum award for non-economic damages to roughly $1.1 million.

While trial lawyers have postured and threatened major action on MICRA before, this latest effort is made credible by the nearly $1 million the lawyers recently put into a ballot measure committee. The proposed ballot language, put forward by a trial lawyer front group inappropriately named Consumer Watchdog, was cleared by the Attorney General for MICRA opponents to begin collecting signatures to place the measure on the November 2014 ballot. Trial lawyers and their allies are bankrolling the proposed initiative.

With money on the table and signature gatherers on the street, it's clear that MICRA opponents are serious about overturning the law in 2014.

If successful, these efforts would be devastating to California's healthcare system. More meritless lawsuits will lead to reduced patient access to our healthcare professionals—and fewer options for affordable, quality healthcare—especially in rural and underserved communities. With federal healthcare reform expanding coverage for millions of additional patients, California is already struggling to provide access to care for the neediest and most vulnerable patients. If this ballot initiative is successful, it will only make the situation worse: even longer lines in emergency rooms, extended waits for appointments with specialists and reduced access to women's services. This measure will make healthcare professionals, including doctors, nurses and other providers, less accessible—not more accountable, as claimed by the trial lawyers.

A broad-based coalition of nearly 1,000 groups and organizations led by CMA—including doctors, nurses, dentists, hospitals, Planned Parenthood and community health centers and clinics, among others—has emerged to protect access to care across the state.

While the latest fight over MICRA has now taken its first steps toward the ballot box, CMA and its allies have already notched several key victories in this fight, and remain committed to defeating the initiative push in its entirety.

The central intent of the proposed ballot language is nothing more than a thinly veiled money grab by California's trial attorneys, who stand to make hundreds of thousands of additional dollars on every malpractice case should the cap be changed. Since most voters would not support that provision, the ballot language also calls for physician drug testing and a bolstering of the state's Controlled Substance Utilization Review and Evaluation System (CURES).

Currently, MICRA protects patients involved in medical liability lawsuits by allowing unlimited economic compensation for any and all economic or out-of-pocket costs, including past and future lost income and earning capacity, all necessary medical care, as well as unlimited punitive damages. Under MICRA, patients can also receive up to $250,000 for non-economic pain and suffering damages. This allows legitimate medical liability cases to move forward while discouraging lawyers from filing frivolous suits. MICRA also limits how much lawyers can take as payment, ensuring more money goes to patients, not lawyers.

The trial lawyers' measure would not only nearly quadruple MICRA's non-economic damages cap from $250,000 to $1.1 million—it would also triple the legal fees that lawyers receive.

While the trial lawyers get rich, ev-

Dr. Thorp, a Paradise internist, is president of CMA.

eryone else pays. More lawsuits mean higher healthcare costs for all. An analysis by California's former independent legislative analyst found that this measure would increase healthcare costs for consumers and taxpayers in California by nearly $10 billion annually.

This fall, MICRA opponents also attacked the Capitol, where members of the Legislature were returning from their summer recess and preparing to begin the final legislative push for the 2013 session.

Knowing that legislation attempting to scrap MICRA would never survive the vetting process typical of a full session, opponents sought to find an author willing to use the so-called "gut-and-amend" action to avoid public scrutiny provided through the regular legislative process to push an anti-MICRA bill through the Legislature in the final days, or even hours, before the Assembly and Senate adjourned for the year.

In its effort to locate an author, as well as drum up opposition to MICRA, Consumer Watchdog began conducting daily mail drops featuring their "38 is too late" campaign to legislative offices. The canvassing project targeted physicians as being unsympathetic to their patients' needs, and portrayed MICRA as a barrier to victims seeking restitution for medical malpractice. Nowhere in Consumer Watchdog's literature did it mention that medical malpractice victims are entitled to unlimited economic damages—such as lost wages, earning capacity and medical expenses—under California law. Nor did it mention that lawyers would stand to make more money should MICRA be overturned.

To combat this effort, CMA and a host of allies—including labor groups, public safety entities, allied healthcare professionals and municipal interests—inundated members of the Legislature with facts supporting MICRA's efficacy, warning that altering the cap would adversely impact local governments, community clinics and insurance premiums for all Californians.

In the end, MICRA's supporters emerged victorious, as trial attorneys were unsuccessful in getting anti-MICRA legislation introduced during the most recent session.

Shortly after being defeated in the state Capitol, MICRA opponents decided it was time to start playing dirty.

In late September, Consumer Watchdog distributed a mail piece featuring the names of hundreds of California physicians who it claims are afraid to "pee in a cup," while also personally targeting CMA Past President Dr. Paul Phinney, asking what he had to hide by opposing the trial attorneys' greed-fueled initiative to gut MICRA. Oddly enough, the trial attorneys' mailer makes no mention of the proposed initiative's attempt to nearly quadruple MICRA's cap on non-economic damages and exponentially increase their fees, and sticks to the more voter-friendly provisions regarding substance abuse in the workplace.

The attack was a brazen one, illustrating that the state's trial lawyers and their puppet organization, Consumer Watchdog, will stop at nothing to line their pockets through the inflated attorney fees that would be generated from MICRA's cap being lifted.

These cheap shots continued, however, when representatives from Consumer Watchdog crashed CMA's annual House of Delegates conference in Anaheim, hosting a press conference outside of the conference center before circling the streets with a video truck broadcasting the message that "doctors should pee in a cup."

While these attacks may sting for those who are personally targeted, they also illustrate one fact—MICRA opponents are desperate.

In the months since trial lawyers launched their latest assault against MICRA, California physicians and other allies have rallied to MICRA's defense at a near-historic rate. Funds are being raised at record numbers, and physician engagement with the issue grows every day. As a result, Consumer Watchdog and other MICRA opponents are stooping to new lows in an attempt to intimidate those who have come to MICRA's defense.

These deceitful attacks by MICRA opponents will continue, and will get worse as the November 2014 election cycle ramps up. Physicians, however, must continue to advocate for MICRA and ensure that our patients and practices are not jeopardized by the greed of those who would like to see MICRA fall.

Rest assured, CMA will win this fight, but will need all physicians in order to do so. To find out how you can help, visit www.cmanet.org/micra today. ◇

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CMA Tackles Governance Issues

Irina deFischer, MD

The Marin Medical Society is 115 years old and is looking to redefine its role in a rapidly evolving healthcare environment. The needs of our members have changed, but I believe that MMS has an important role to play as the umbrella organization for physicians of all specialties and modes of practice. We will continue to advocate for the patients of Marin County and for our profession on the local, state and national levels.

On Oct. 10–13, several MMS members, along with MMS staff, travelled to Anaheim for the annual CMA House of Delegates meeting. Dr. Jeffrey Stephenson, an occupational medicine physician in Novato, attended for the first time as a Marin delegate. Dr. Cuyler Goodwin, a psychiatry resident at UCSF, attended as part of the Resident and Fellow Physicians section, and he was elected as their representative to the CMA board of trustees. Dr. Kimberly Schrage, an emergency physician from Kaiser San Rafael, was part of the Very Large Group Practice Forum delegation. Dr. Peter Bretan, a Novato urologist, was there as the District X trustee on the CMA board , and I was there as a delegate from Marin, as well as chair of the District X delegation. (District X includes Marin, Sonoma, Solano, Napa, Mendocino, Lake, Humboldt and Del Norte counties).

Dr. deFischer, a family physician and geriatrician at Kaiser Petaluma, is president of MMS.

The House of Delegates (HOD) is the policy-making body for CMA, and each year we meet to consider over a hundred resolutions submitted by members on a large number of topics. This year the reference committee on Science and Public Health was a virtual one, meaning that any CMA member was able to submit online testimony on the resolutions up to one week before the HOD.

One of the most hotly contested issues at this year's meeting concerned the Governance Technical Advisory Committee report, which consisted of several recommendations on CMA governance. The first recommendation was to adopt a year-round resolutions process, whereby individual CMA members could submit issues for consideration at any time, and they would be assigned by the board to standing councils and committees, which would study them, review testimony, and return reports with recommendations for action by the board. This recommendation was approved.

Also approved was a recommendation to strengthen the councils and committees and give them a bigger role in CMA policy making. Further approved recommendations included shortening the HOD to two days and limiting discussion to a handful of the most important issues, as determined by speakers of the HOD and the Speakers Advisory Committee, comprised of all the delegation chairs.

There was also a recommendation for changing the way AMA delegates and alternates are chosen. Currently we use a purely geographic model whereby the CMA districts elect the number of AMA delegates and alternates to which they are entitled, based on the number of AMA members in their district. District X has one delegate, Dr. Michael Sexton, and one alternate, Dr. Peter Bretan, while the larger counties have several delegates and alternates. The new model would allow for one delegate and alternate to be elected by each district, and for the remainder to be appointed by the CMA board of trustees, which would give CMA leadership greater say in the composition of the AMA delegation. This proposal generated a great deal of controversy but was ultimately approved. A final recommendation to reduce the size of the board of trustees from over 50 members to fewer than 30 was approved as well, but the details are still to be determined.

Change is painful, yet I am hopeful that the streamlining from these resolutions will make CMA and MMS more nimble organizations, able to respond quickly to the issues that face us.

The 2014 House of Delegates is scheduled for Oct. 17–19 at the nearby Sacramento Convention Center. I would strongly encourage more colleagues to become involved and possibly attend! ◇

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